UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

GERALD CORNELIUS ELDRIDGE	.	C.A. NO. H-05-1847
	.	HOUSTON, TEXAS
VS.	.	
	.	APRIL 18, 2012
RICK THALER	.	9:00 A.M. to 11:30 A.M.

DAY 3 of 3
TRANSCRIPT of EVIDENTIARY HEARING
BEFORE THE HONORABLE LEE H. ROSENTHAL
UNITED STATES DISTRICT JUDGE

APPEARANCES:

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Proceedings recorded by mechanical stenography, transcript produced by computer-aided transcription.

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P R O C E E D I N G S

THE COURT: I think we're ready. Dr. Roman. I think we're ready on the redirect.

THE WITNESS: Good morning, Your Honor.

MS. FERRY: I think they're bringing in Mr. Eldridge.

THE COURT: All right.

MS. FERRY: And I just wanted to alert the Court that at the conclusion of today's hearing, Mr. Wiercioch would like to make a few, again very brief, ex parte representations about the matter we discussed.

THE COURT: We'll either do it now or in advance -- while we're waiting for Mr. Eldridge, let's talk just about the plane matters that we were talking about. Did you have a chance to check on the availability of flights?

MR. WIERCIOCH: Yes, I did, Your Honor. And the ticket prices are substantially lower for the May 29th setting.

THE COURT: Were you able to get a seat, that was the main thing you were looking at, because of the Memorial Day weekend?

MR. WIERCIOCH: Yes, I will be able to get a seat.

THE COURT: All right. Great. So, we're on for the 29th. We'll start at -- let me check. So, we'll start on the 29th at 9:00 o'clock, and hopefully we will be able to finish in the -- by the end of the day on the 30th. Does that make sense?

MS. FERRY: Yes, Your Honor.

THE COURT: All right. I think we're ready. The Court notes Mr. Eldridge has been brought into the courtroom, and we're ready to proceed.

(Michael A. Roman, petitioner's witness, previously sworn.)

REDIRECT EXAMINATION

BY MS. FERRY

Q. Now, Dr. Roman, you were asked a number of questions by Ms. Oden yesterday about the records you reviewed in this case and whether you reviewed every page of the respondent's exhibits for this hearing and every page of the respondent's exhibits for the Atkins hearing. Do you have unlimited funding in this case?

A. No, ma'am, I do not.

Q. The funding that we discussed during your direct examination, does that include the entirety of funding that's been approved for your work, including all document review, writing your reports, seeing Mr. Eldridge, preparing for this hearing, and testifying in this case?

A. Yes, ma'am.

Q. Now, you also were asked a number of questions about which exhibits -- excuse me, which pages of the TDCJ mental health and other records you specifically referenced in your report and which ones you didn't. Were your reports intended to be an exhaustive summary of all of the TDCJ mental health records in

this case?

A. No, ma'am, they were not.

Q. Would it have been realistic for you to attempt to write a report like that?

A. I never have and don't think it's realistic or productive.

Q. Now, I would like to go through with you the records that document Mr. Eldridge's food delusions over the years and talk with you about some records that weren't brought out yesterday. And for efficiency sake, rather than pulling out each record that you discussed with Ms. Oden and then each record that you didn't, we're going to do this looking at respondent -- excuse me, Petitioner's Exhibit 10, which is the table summarizing records related to food delusions in the TDCJ records and includes dates and reference to the exhibit and page number.

And, so, let's start with looking at page 1 of Exhibit 10 here. And is -- yes. So, you see that page 1 includes reference to food delusions documented in 2001 in the TDCJ records; is that right?

A. Yes, I see that.

Q. And I'm correct that there are more than two references here to Mr. Eldridge reporting his food delusion in 2001, correct?

A. There are more than two references.

Q. In fact, there are ten references here in 2001; is that right?

A. I may have made it as many as 12. Two, four, six, eight, ten -- I believe I count 12.
Q. Well, I'm excluding --
A. Yes.
Q. -- this third entry here, "So far has missed six meals," as well as the second entry, "States he is on hunger strike," because that doesn't specifically reference a food delusion. That can mean any number of things, right?
A. Exactly, yes, that's true.
Q. Okay. So, now let's look at the complaints for 2002, which begins on page 2 and continues over -- excuse me, begins on page 1 and continues to page 2 of this exhibit. Here at the bottom of page 1, we see a report made on January 17th of 2002, correct?
A. Yes.
Q. And then looking over on page 2, we see an additional one here at the bottom of page 1, one, two, three, four, five, for a total of six; is that right?
A. Yes, that's correct.
Q. And here on page 3 of that same exhibit, let's do the same thing for the food delusions documented for the year 2004. And am I correct that there are four here that specifically reference his food delusion?
A. Again, I see five entries. Without reading the text, certainly there are at least four.

Q. Okay. And then there's also, is there not, an entry of documentation of Mr. Eldridge complaining in 2005, "Patient only complaining about how he believes security is tampering with his food and his mail"?
A. Yes, ma'am, there is.
Q. And that was made on December 8th, 2005, right?
A. That's correct.
Q. And, now, page -- excuse me. Complaints for the year 2006, which begin here on page 3, and here on page 3 we have one, two, three, four -- I'm looking at the back here on page 4, four -- oh, excuse me, five, six. So, there are a total of six separate occasions in 2006 that Mr. Eldridge complained about his food being poisoned, correct?
A. I believe there's seven. There's one you passed over that I think is an indication of food, but there are at least six, yes.
Q. Okay. So, possibly seven. All right. And now that we've established that, let me ask you about the discussion that you had with Ms. Oden yesterday about the possibility of Mr. Eldridge having delusional disorder. When you were discussing that with Ms. Oden yesterday, were you purporting to definitively diagnose Mr. Eldridge with a delusional disorder for the years 2001 and 2002?
A. No, ma'am, I was not.
Q. And was it your intent to definitively rule out the

possibility of delusional disorder for the years 2003 to 2008?
A. No, ma'am, I was not.
Q. So, explain for us what it is that you're saying about the possibility of Mr. Eldridge having a delusional disorder during the period of time from 2001 to 2008.
A. As I understood the questioning, at that point we were talking about specific periods of time in the records and what they seem to suggest in terms of symptomatology and diagnostic significance. Obviously going back in records retrospectively can be difficult without seeing the patient.

In looking at that and attempting to characterize the extent of evidence that I thought was present within a particular year and whether it rose to a significant level, this was the basis on which I suggested that if we looked at the record in isolation in that year as it exists, whether or not I believe that it rose to a level that might potentially merit a diagnosis, obviously that we were back in that time and could establish that the diagnosis was accurate. It's difficult to do retrospectively.

Q. Now, along the same lines let me ask you, Ms. Oden was asking you questions about whether or not a person can be schizophrenic in the morning but not at night and vice versa and you two had an exchange about that and I think there was possibly a disconnect between you two. When you answered those questions in the affirmative, am I correct that what you --

tell me if this is right. My understanding is that what -- is that your intent was to say that the symptomatology of schizophrenia could be present in the morning, could not be documented in the evening and vice versa, or were you saying that a person could have schizophrenia in the morning and could not have schizophrenia at night?

A. No, I was not saying the latter. If a person is schizophrenic, they are schizophrenic 24/7. Whether they manifest symptomatology that an observer would say clearly I see evidence that supports that I know this person is schizophrenic, that could occur in the morning. It could occur in the afternoon. It could occur in the evening. By the same token, it could occur in one part of the day and potentially not be obvious to an observer in another part of the day, but they are still schizophrenic. It's a significant and serious condition.

Q. Now, let me ask you about Respondent's Exhibit 23 at page 13. Do you recall discussing this record with Ms. Oden yesterday? And this is an integrated progress note, dated October 31st, 2001. And if we look here on page 14 of that, we see that it was -- that these are notes made by C. Woodrick, Ph.D.

A. Yes, I remember discussing it. I looked at so many documents yesterday, I can't recall whether this is one that was put up on the Elmo or not, offhand. But, yes, I certainly

remember discussing this.

Q. Okay. And as I recall it, you and Ms. Oden were talking about whether you saw this record, whether you considered it, and then she was asking you the questions about why this particular record isn't documented in your report.

Now, let me ask you to look with me here at page 5 of your initial report, which is Petitioner's Exhibit 1, the second full paragraph here. That's the paragraph in your report where you discuss Mr. Eldridge's admission to Jester IV in 2001, some observations that were made, and his ultimate discharge, with the conclusion that he was, quote, "rather flagrantly attempting to present symptoms of multiple personality disorder, slash, dissociative identity disorder by claiming four different personalities. He gives the impression of a well-rehearsed act designed to obtain a mental health jacket for secondary gain."

Am I correct in characterizing that paragraph of your report?

A. Yes, that's an accurate characterization.

Q. So, no question that you reviewed, considered, and documented in your report Mr. Eldridge's 2001 admission and ultimate discharge from Jester IV, right?

A. Yes, ma'am, that's correct.

Q. And with respect to this particular record that Ms. Oden was asking you about, Respondent's Tab 23, page 13, as I said,

it's a record from -- created by Dr. Woodrick dated October 31st, 2001. And now I'm going to put here on the screen Respondent's Tab 23, page 18, and you see here that's a psychosocial report based on an evaluation conducted on October 31st, 2001, by Charles P. Woodrick, Ph.D., right?

A. Yes, I do see that.

Q. And this record goes through page 22 of Respondent's Tab 23, and this is the record -- this certainly is one of the records that you reviewed to write your report -- this paragraph in your report dealing with Jester IV?

A. It is, I recall reviewing it.

Q. And, in fact, this record is the ultimate report that was created by Dr. Woodrick based on these notes that are here on page 13. That's what that appears to be, correct?

A. That is what it appears to be, yes.

Q. Now, you were also asked a number of questions yesterday about whether you would be surprised to learn about various possibilities about TDCJ mental health staff's knowledge of malingering, their approach to malingering -- their approach to determining whether an inmate is malingering. Do you recall that questioning?

A. I recall that line of questioning, yes.

Q. So, I want to ask you some questions about what we know about TDCJ's approach to malingering. Based on Dr. Nathan's testimony, is there any question in your mind that from the

period of 2009 up to the present, that TDCJ mental health staff are permitted to use the malingering label?

A. There's no question in my mind that that's an accurate statement, that they are permitted to use it.

Q. And is there any question in your mind about whether Dr. Nathan himself always considers the possibility of malingering, based on his testimony?

A. Based on his testimony, I was given the firm impression that he always considers malingering within his treatment considerations.

Q. Now, Dr. Roman, you're aware that in the psychosocial evaluation conducted by Dr. Woodrick in 2001, that we were just discussing on the Elmo, as well as the ultimate discharge report from 2001, that the specific term "malingering," that term wasn't used in either the psychosocial evaluation or the ultimate discharge paperwork; is that right?

A. As I recall the records, I believe that's an accurate statement, that it was not used.

Q. But do those 2001 Jester IV records, both Dr. Woodrick's psychosocial and the ultimate discharge report, in your opinion, do those records make clear that TDCJ mental health staff were looking at the possibility of inmates feigning symptoms?

A. Furthermore, it suggests that they felt that he was doing exactly that and that his symptoms were not consistent with

anything real, yes.

Q. And, so, is there any question in your mind that TDCJ staff have proven themselves perfectly capable of determining if an inmate is putting on an act?

THE COURT: During what period? Because the testimony was that there was a change in TDCJ's approach towards the consideration of malingering over a period of time.

MS. FERRY: And, Your Honor, I'm asking --

THE COURT: So, perhaps if you could tie it to particular periods, that would be helpful.

MS. FERRY: Certainly.

BY MS. FERRY

Q. So, we've already discussed the fact that based on Dr. Nathan's testimony, from 2009 to the present, no question about the permissibility of using the term "malingering"?

A. This is my belief, yes.

Q. And I'm now asking you about based on the 2001 Jester IV records --

A. Yes.

Q. -- based on those records, even when the specific term "malingering" was not used, based on those 2001 records, is there any question in your mind about whether TDCJ mental health staff were capable of determining whether an inmate --

A. Right.

Q. -- was putting on an act?

A. No. It seems to correspond to the time that Dr. Nathan said that they perhaps were not using the word "malingering," but the records suggested to me that the conclusions they drew were consistent with the label of malingering even though it was not applied as a specific word.

Q. And even though that specific word wasn't used, this summary that you have here of that record on page 5 of Exhibit 1, where they write things like, "He gives the impression of a well-rehearsed act designed to obtain a mental health jacket for secondary gain," this 2001 record indicates that even without using the label "malingering," certainly in 2001 they were capable of getting across the idea that an inmate was not genuinely reporting symptoms of psychosis, right?

A. Yes, ma'am. It is an operational definition for malingering or feigning of symptoms.

Q. Now, I would like to talk with you about the TDCJ mental health record found at Respondent's Tab 23, page 214. And if you look with me, that record begins on page 212 of that exhibit and on that page we see this is a record from December 23rd, 2009, created by the Jester IV unit; is that right?

A. I see that. That's correct.

Q. And, so, now let's look at page 214 of that same exhibit. And under subjective, here it states, "Today he reports I'm hearing voices of my brother Michael who has been telling me to

watch out for everyone. He states that everyone is out to get me."

Now, do you recall discussing this record with Ms. Oden yesterday?

A. I do recall discussing that record.

Q. And you two had a discussion about why, in your opinion, you could not precisely resolve the time frame in which Mr. Eldridge's reporting here's when I heard voices, and I'd just like you to explain to us why it is, based on the language that's here in this report, "Today he reports I'm hearing voices of my brother," why can you not resolve the precise time frame that that audio hallucination is being reported?

A. Certainly. So, when we review a record, it's our intent to attempt to not read things into it and be as objective in the review as possible. There are a couple things that I see. When the heading under subjective states "today he reports," what I know definitively or can at least definitively assume that I know is that this is a report that he made today. So, I totally concur with the fact that what follows is something that was told to this examiner on this particular day.

When it says, "I'm hearing voices of my brother" and some of those other things, I don't know if when that examiner sat with him, if that examiner was saying, "So, Mr. Eldridge, you know, how are you doing today? You know, what's been going on? It's been a couple of days since we

met," or whatever that may be and perhaps he says, "Well, I'm hearing voices of my brother," which could suggest that that's happened two days ago or a week ago or ten minutes ago. I have no idea.

If the record said, "This morning I heard voices of my brother" or, "I'm hearing my brother talking to me right now," it's obvious to me that it's here and now. That may be what's happening. But for me to conclude that requires an inference on my part. I don't know when he was hearing voices.

Q. And let me ask you this: Based on both your neuropsychological testing of Mr. Eldridge as well as the three different times that you have evaluated him in person, including two quite lengthy clinical interviews -- excuse me, not clinical, but two lengthy interviews, structured interviews, do you have concerns about the precision with which Mr. Eldridge uses language and that he reports various events occurring?

A. I believe I've given that testimony before, yes, I do have that concern.

Q. So, in other words, just -- are you being difficult about this record?

A. I am sincerely hoping not to be difficult. I would also add that at certain places in the record, things that Mr. Eldridge has said has been included in quotes. One of the things that we look at is that if somebody includes quotes, we

assume that that is a verbatim or as close to verbatim as one was able to keep up with in their note-taking rendition. If there aren't quotes, that typically is an indication that we're paraphrasing or somehow indicating what was said. So, we have that as an additional consideration here. So, not only is it not being sure about how he used the language, but I have reason to believe that ultimately it's that observer or evaluator, if you will, paraphrasing the take that they had from whatever he shared.

Q. Now, let me ask you this: There was discussion yesterday about the crime scene photographs that you showed to Mr. Eldridge during -- I believe it was during your initial evaluation -- excuse me, I suppose it was in May of 2010.

A. The second date that I saw him, which was my initial testing evaluation, yes, ma'am.

Q. So, May of 2010 when you showed him those photographs. And during the course of that discussion you were having, there was some discussion about at what points in the record there is documentation of Mr. Eldridge making reference to Chirrsa. And am I correct that it's your testimony that there was this discussion that he had with Dr. Silverman, in Dr. Silverman's pretrial competency report, where Chirrsa is discussed; is that correct?

A. Yes, ma'am, that's correct.

Q. And that --

MS. FERRY: Excuse me, Your Honor. I just realized I don't have that.

BY MS. FERRY

Q. And that would be Tab -- excuse me, page 14 of Respondent's exhibit -- I believe it is 55.

THE COURT: 55?

MS. FERRY: 55, yes.

THE COURT: Thank you.

BY MS. FERRY

Q. And that's here on page 15. And this is a document that we discussed during your direct examination, correct?

A. Yes, it is.

Q. And here there are references to both Cynthia and Chirrsa, in response to doctor -- in response to what appears to be Dr. Silverman directly raising the capital murder charge with Mr. Eldridge?

A. That's how I understood that section of the document, yes.

Q. Which wouldn't be surprising, because Dr. Silverman is specifically there pretrial to discuss his competency to stand trial on those charges, correct?

A. That's correct, yes.

Q. And you also mentioned that, of course, in Dr. Allen's report there's discussion of -- well, there's documentation of questioning of Mr. Eldridge about Cynthia and Chirrsa, right?

A. Yes, ma'am, that's correct.

Q. And then, of course, in your report, you discuss showing Mr. Eldridge those crime scene photographs?
A. Yes.
Q. And in response to you showing Mr. Eldridge the bloodied, rather gruesome photographs of both Cynthia and Chirrsa, Mr. Eldridge's response was, "So, it must be true. I must have did this," right?
A. He said that at the end, after returning the photographs, yes.
Q. Now, explain for us, Dr. Roman, why it is in light of Mr. Eldridge making that statement, "So, it must be true. I must have did this," that you can nevertheless conclude that Mr. Eldridge does not, as he sits here today, have a rational understanding of the fact that he is responsible for murdering Cynthia and Chirrsa Bogany?
A. There are probably several elements, but the most direct one that comes to mind is, as I review the record, as I have suggested, I know of only those two places, the one that was put up on the Elmo from Dr. Silverman's report and the later reference that exists in Dr. Allen's report. I don't recall that I saw a specific mention from Mr. Eldridge in Dr. Allen's notes, but I simply may not recall that. Those are the only two times that there is an indication that he has made a specific reference to Chirrsa. Every other time that he is asked about the capital crime in some fashion, the question of

why he's in prison, he has responded with, "I shot someone -- they say I shot someone." Almost every time. I can't say with a certainty that it's every time.

You then have to prompt him with, "Who do they say you shot," and then he will say, "They say I shot Cynthia." Sometimes he will spontaneously add, "You know, but I see her. But she's alive." Many times he doesn't and you have to ask him something about that and then he'll look at you and say, "But, you know, I've seen her. She's alive."

I know of no other time that he has ever stated that he has even an awareness that he has shot or been accused of shooting, other than those two references that I've mentioned, Chirrsa. Indeed, even when I showed him the photographs and he looked at Cynthia's picture, he said -- and I have to look at my report to get the quote and I can do that if you would like, but he acknowledged that he understood that to be Cynthia. He said nothing one way or another about looking at Chirrsa at that time. He did not acknowledge it was her. He didn't refute it. He spoke no words regarding her or her name.

Q. And, again, based on your subsequent interaction with Mr. Eldridge during your December 2011 structured interview of him, why does it appear to you that whatever -- to the extent that some reality briefly sort of came to Mr. Eldridge when you showed him those photographs, why is it your belief that that

certainly has not stayed with him?
A. Several things. Again, in interviewing him on that final date in 2011, we went through the same kinds of things in terms of why he was there in prison and, again, he responded in the same basic way. Chirrsa certainly did not come up again. He had the same degree of uncertainty or denial or whatever we want to call that dimension where he certainly appeared to not be in sync with what he was able to report as something other people have stated he did.

He seemed to recall seeing the photographs in the most vague of terms, the fact that he saw some bad pictures or bad photos, but said nothing about the content of them and did not seem to recall anything about the content.
Q. Now, I would like to turn with you to the discussion that you had with Ms. Oden yesterday about Mr. Eldridge's jail mail. And as far as you know, have you reviewed every piece of personal correspondence that's been collected for Mr. Eldridge?
A. I don't know, because I don't know how much he's done. I mean, he's been there a long time and I'm going to assume that there are probably some letters that I haven't seen, but I don't know for sure what the totality of the documents is. It hasn't been represented to me whether or not I've seen every piece of mail.
Q. Well, let me ask you this, then, because I take your point, that Mr. Eldridge has been on death row for quite some time and

you have not reviewed mail going back to his incarceration in 1993. Have you reviewed mail from the point of 2010 up to the present? Does that sound correct, about the date of mail that you began to review?

A. Yes, I think it's possible that I've reviewed everything that exists perhaps going as far as back as 2009.

Q. Now, are there -- you just said to Ms. Oden that you're aware that Mr. Eldridge was scheduled for execution on November 17th, 2009, right?

A. I do know that, yes, ma'am.

Q. And in the days and weeks leading up to November 17th, 2009, are there any letters in Mr. Eldridge's personal correspondence in which he writes to family members to say good-bye?

A. There are none.

Q. Are there any letters in which he writes to any of his various pen pals to say good-bye in the days and weeks leading up to that execution date?

A. There are none.

Q. And now I want to look with you at page -- Respondent's Tab 23, pages 137 through 138, which is a TDCJ mental health record from the Polunsky unit that up here at the top is dated November 19th, 2009, but looking down -- midway down the page we see the notation, "This is a late-entry note. Patient seen cell side on 12 building at 15:35 on 11-17-09."

A. Yes, I recall that document.
Q. Okay. And as we just discussed, that would be the afternoon -- this is a notation of observations made on the afternoon of Mr. Eldridge's scheduled execution, right?
A. Yes, ma'am, that's correct.
Q. And looking at page 138 of this note, as you discussed with Ms. Eldridge -- excuse me, Ms. Oden yesterday, we see here that Mr. Eldridge's grooming is reported to be normal; his motor activity is reported as unremarkable; affect, appropriate; mood, euthymic -- is that how to pronounce that?
A. Yes. Yes, it is.
Q. And what does "euthymic" mean?
A. Euthymic means that it was fairly neutral. It was neither happy nor sad. It was just sort of normal.
Q. Speech flow is normal. Thought content is appropriate to mood circumstances. Thought organization is logical and goal directed. Self harm, none reported or noted. Harm to others, none reported or noted.

Essentially this record says -- this record indicates that it appeared to this mental health clinician that Mr. Eldridge seemed sort of generally fine, right?
A. I think that's an accurate appraisal of what's listed, yes.
Q. If you were to look solely at this record and were asked to determine whether the person described here is mentally ill, am I correct that you would say there's no evidence here that this

person suffers from schizophrenia, right?
A. If this was the sole record, no, I wouldn't think of any type of mental illness based on this report.
Q. Certainly no evidence here that on the afternoon of his scheduled execution, Mr. Eldridge was calling attention to himself, saying, "Hey, I'm hearing voices. Hey, I need mental health treatment," right?
A. Based on this record, that certainly is an accurate appraisal.
Q. Now, Dr. Roman, let's -- I want to ask you a hypothetical question. Let's assume for a moment that it's your conclusion in this case that Mr. Eldridge is malingering -- okay? -- that he does not suffer from schizophrenia, that all the complaints and signs of psychosis documented from 2009 to 2012 are all malingered. Okay?
A. Okay.
Q. Let's assume that it's your conclusion that he's pulled the wool over the eyes of all of the treating mental health staff at TDCJ during that time and that doctor -- excuse me, that Mr. Eldridge is doing this based on what he learned during his pretrial competency hearing, what he's learned from various other inmates who have gone through the competency process. Let's assume that. Okay? That your assumption is Mr. Eldridge has been able to gather information about what he needs to do to prevent himself from being executed and that he is able to

execute that plan extremely well so that he's pulling it -- he's pulling it over on all those TDCJ mental health professionals. Okay?

A. Okay.

Q. Now, if they were your assumption, if that were your conclusion in this case, let me ask you this: Would this record from the very afternoon of Mr. Eldridge's execution, would this record seem odd to you?

A. That hypothesis would lead me to believe that he knew that this was his execution day. This would be a date that essentially he had scored a particular victory in having pulled the wool over people's eyes. It would seem to me that it would be a day where he would be most likely to want to show evidence of the very things that, in your hypothetical example, he has concocted to impress people or that he might seem somewhat happier about his victory. But generally I would expect that he would have evidence of some degree of positive symptoms of schizophrenia that would help to punctuate the fact that he is schizophrenic.

MS. FERRY: And that's actually all I have right now, Judge.

THE COURT: All right. Thank you. Anything further?

MS. ODEN: Just briefly, Your Honor. If I may question from here, Your Honor?

THE COURT: That's fine.

RECROSS-EXAMINATION

BY MS. ODEN

Q. Dr. Roman, you would agree that the DSM does establish criteria for the mental illnesses or disorders contained within that book?

A. Yes, of course.

Q. And professionals in your field rely on that book and rely on the diagnostic criteria to give some uniformity across the profession in terms of diagnoses?

A. That is correct.

Q. And, so, a doctor in California that diagnosis someone with schizophrenia, although the actual symptoms will potentially vary, that diagnosis would be as reliable as a doctor in New York, because they would both theoretically be applying the same diagnostic criteria?

A. Assuming that, indeed, they've applied the same diagnostic criteria, yes, indeed, it would.

Q. Right. And you would probably also agree with me that it's important that doctors apply the same diagnostic criteria?

A. Yes, I would agree with that.

Q. Do you apply the diagnostic criteria that are found in the DSM?

A. Yes, I do.

Q. And that's important that you do that, because it means that you are adhering to the standards of your profession?

A. And it's important that you do that because it's a way of appropriately characterizing the symptomatology that's presented, yes, ma'am.
Q. And that helps you as a clinician to give the appropriate treatment based on the appropriate -- whatever the disorder really is?
A. Well, rarely does anybody treat the diagnosis. We treat symptomatology. So, the question of whether diagnosis is directly relevant to treatment, in some cases it is, but most frequently symptoms direct treatment. So, diagnosis is important for communication.
Q. Well, it's also important because you don't want to treat someone for a symptom, if they only have the symptom one time.
A. That's definitely --
Q. You want to make sure that it is a symptom based on a disorder and, therefore, the symptom probably will appear more than once?
A. That definitely is an accurate statement, yes, ma'am.
Q. But it's also important to you when you are performing your role as a forensic psychologist -- which in this case you are a forensic psychologist, correct?
A. In the way that you define that, yes, that is an accurate statement.
Q. Okay. How about the way that you define it? Did you view your role in this case as a forensic psychologist?

A. Certainly. It's a forensic case. I think when we talk about forensic psychologists, as I think you pointed out, we talk about a certain degree of education, a way of coming at something. I'm always a neuropsychologist. So, if you want to talk about me as a forensic neuropsychologist, I would be wholly comfortable with that label.

Q. And, so, when you approached this case, you were trying, I would imagine, very hard to stick to the professional standards and the diagnostic criteria that would be appropriate not just from a clinical standpoint but from a forensic standpoint?

A. Yes, ma'am.

Q. So that you could best aid the Court?

A. Yes, ma'am.

Q. Okay. You made your diagnoses based on the criteria in the DSM?

A. Yes, ma'am.

Q. Now, when we were talking about the Woodrick reports versus the Woodrick notes, specifically dealing with those records on October 31st, 2001, the multiple personality --

A. I know which ones you mean, yes, ma'am.

Q. -- event -- I understand there is a lot of data in this case, right?

A. There is a lot of data in this case.

Q. And it's hard to keep it all straight?

A. It's hard to keep it all straight when you're being asked

about specific records without the benefit of being able to review those records.

Q. That's very understandable. It's hard to remember without having them in front of you exactly what you've seen and what you haven't seen?

A. If one assumes that one hasn't seen everything, then, yes, your statement is true. If --

Q. And it's possible that you haven't seen all of the records in this case?

A. Given the number of years that he's been on death row and given that you have described to me there are some documents that I haven't seen, some exhibits and so forth, yes, I believe that that's probably accurate.

Q. And we discussed yesterday that because you reviewed the respondent's exhibits that were sent to you in pdf format, it's difficult for you -- I don't know if the box is still there, but it's difficult for you to know if you reviewed a box of four binders' worth of paper, because you were looking at it on the computer?

A. Right, it's a different metric. I would almost have to do a page count, which I guess would be doable, but, yes, it's hard to simply look and say this pdf is as thick as this binder.

Q. But you would agree that the wording of Dr. Woodrick's notes presumably taken at or near the time that he was

interviewing Mr. Eldridge, did describe some things differently, did use different wording than what was actually in his report?

A. Yes.

Q. And would you agree with me that reading Dr. Woodrick's in the moment notes seem to give a fuller flavor to what Mr. Eldridge had reported at that time than you got from actually the psychosocial report?

A. I don't know if I would agree with that or not.

Q. Okay. When we talk about TDCJ's approach to malingering, you do remember Dr. Nathan testifying that with further review of the records, he saw serious signs of malingering?

A. I recall him indicating that as particular records were presented, that he felt that those aspects and certain hypotheticals that were raised he thought were suspicious or suggestive of malingering, yes, ma'am.

Q. And you recall Dr. Nathan testifying that he had actually only seen Mr. Eldridge four times?

A. I didn't remember the number, but, yes, that seems to comport with his testimony.

Q. And he never actually interviewed him in person?

A. That is what I understand, yes.

Q. And in 2001 you would agree with me that Mr. Eldridge's presentation was much more dramatic than it was --

A. I'm sorry. In what year again?

Q. 2001.
A. Yes.
Q. So, we're talking still about the records in 2001 where Mr. Eldridge was feigning the multiple personality disorder, et cetera?
A. Well, as you know, I don't believe he was ever feigning a multiple personality disorder, but I understand the records you're referring to.
Q. So, you disagree with Dr. Woodrick's conclusion that he was feigning multiple personality disorder, but you understand that those are the symptoms that Mr. Eldridge was presenting, those are the statements he was making?
A. I understand those are the statements that he was making, yes, ma'am.
Q. Okay. So, you just disagree with Dr. Woodrick's conclusion that those statements were an attempt to feign multiple personality disorder?
A. Right. And respectfully, Dr. Nathan himself said that those are not all of the diagnostic criteria that one would see in a multiple personality disorder, so.
Q. So, basically you agree that Dr. Woodrick was correct in not diagnosing Mr. Eldridge with multiple personality disorder?
A. I absolutely agree he was correct in not making that diagnosis.
Q. Okay. But that is a separate question from whether or not

Mr. Eldridge was attempting to feign the multiple personality disorder?

A. Yes, that would be a separate question, absolutely.

Q. And you would agree that if that is what he was doing, he was not doing a good job of it?

A. I would definitely agree with that, yes.

Q. Okay. Mr. Eldridge's symptoms after 2001 did not appear to be especially noticeable or significant or serious until 2006 when he was hospitalized in Jester IV in part for the psychosis that everybody seemed to associate with his pernicious anemia, right?

A. Well, again, this is difficult. As I think it's been pointed out, there are a number of indications in the record of some continuing symptomatology. So, I know that there is a decrease in the frequency of records that speak to this. Again, when you go back to the question of applying that to what I know about what was happening with Mr. Eldridge, given that, as we've established, I can only get it from the record, I'm more comfortable answering that in the affirmative, if you talk about the record rather than make Mr. Eldridge the direct subject of that question.

Q. Okay. So, instead of talking about Mr. Eldridge's symptoms, we will just limit the conversation for right now to talking about what's in the records.

A. That's fine.

Q. Okay. So, you would agree with me that after 2001, when Mr. Eldridge's records indicated the presentation of multiple personality-type symptoms, after 2001 until 2006, the records don't show an extensive, significant, dramatic amount of symptoms until Mr. Eldridge's records indicate he was hospitalized in part for pernicious anemia and in part for the psychosis associated?

A. It did appear that there were relatively fewer records indicating significant psychopathology between those time frames, yes.

Q. Okay. And then in 2006, the symptoms that are reflected in the records kind of peak while he is experiencing that pernicious anemia episode?

A. We're talking about prior to his treatment, is that --

Q. In 2006, you would agree with me that the records reflect a peak or a rise of symptomatology around the time period that he is hospitalized for pernicious anemia?

A. Well, again, I think we keep getting into this. I will agree that there are more obvious records documenting aspects of reported psychopathology --

Q. Okay.

A. -- during that 2006 period.

Q. Okay. And those symptoms appeared to be connected to a medical cause that nobody doubted in the medical field, correct?

A. I don't know whether those symptoms were necessarily connected to a medical cause. I do know that there was a concomitant medical cause not necessarily of the symptoms but that was identified for him.

Q. Okay. When we talk about things appearing in quotes in the records and things not appearing in quotes in the records, all we can know is that at some point in time some observer felt it appropriate to put statements within quotes?

A. Correct.

Q. That doesn't necessarily mean that all observers all the time will always put all quotes within quotes --

A. I think that --

Q. -- right?

A. -- was well stated, yes.

Q. Okay. Would it be fair to say when we're speaking about the day of Mr. Eldridge's scheduled execution, which is November 17th, 2009, would it be fair to say that if the records reflected a number of positive and negative symptoms of schizophrenia, that the records would reflect a theatrical presentation, a dramatic presentation? I understand theatrical has a connotation of feigning, and I'm not trying to --

A. No, I understand. I understand.

Q. -- imply intent, but you would agree with me that if there were a number of symptoms on that day, that that would be a noticeable and dramatic thing?

A. That would be noticeable, noteworthy certainly, and potentially dramatic, yes.

Q. Okay.

MS. ODEN: No other questions, Your Honor.

THE COURT: All right. Thank you. Anything further?

MS. FERRY: Literally two questions.

FURTHER REDIRECT EXAMINATION

BY MS. FERRY

Q. Dr. Roman, I just want to clear up when you were talking with Ms. Oden just now about the 2001 Jester IV multiple personality issue and just so we're clear, you agree that Mr. Eldridge should not have been diagnosed with multiple personality disorder in 2001?

A. Or at any other point, yes, I do agree.

Q. Now, explain to us what you mean when you say that you don't necessarily agree that Mr. Eldridge was attempting to portray multiple personalities? What do you mean when you say that?

A. Any time we look at symptoms or we look at a person's statement, you know, we are cautioned in the field and I would argue we are particularly cautioned when we are looking with a forensic application about making determinations about a person's motivation. We can't know what their motivations are. We can decide that they might have reasons to be motivated one way or another, but we don't ultimately know -- assuming that

it's not real, we don't ultimately know what they're trying to do or why they might be trying to do it. We infer that.

And I have no idea what to make of that. That was a bizarre record with very bizarre statements. I don't know what it means. I certainly can't conclude it was as specific as him attempting to sell somebody on a multiple personality.

MS. FERRY: That's all I have, Your Honor.

THE COURT: All right. Thank you.

Anything further?

FURTHER RECROSS-EXAMINATION

BY MS. ODEN

Q. Dr. Roman, if we're not here to determine Mr. Eldridge's motivation, why are we here?

A. The issue that we run into and the point that I'm making is that when we look at any particular observation and we ask the question what was the person's motivation for saying this or for doing this particular thing at any given point in time, we can't ultimately know that motivation. This is one of the reasons we look at the totality of the record and one of the reasons we may do, if you will, a tally count of some sort in terms of whether we think that there is a preponderance of the evidence suggesting that their motivation might be one way or their motivation may be another way. It always becomes an inference, but the inference has much more merit when we make

it across a data set than when we attempt to abstract some particular observation or particular symptom and make some determination that we know what their motives were at that moment in time.

Q. Thank you.

MS. ODEN: No other questions.

MS. FERRY: I don't see the need to ask any more questions, Your Honor.

THE COURT: All right. Thank you.

You may step down, sir.

THE WITNESS: Thank you Your Honor.

THE COURT: Does that conclude your witness evidence?

MS. FERRY: Yes, Your Honor.

THE COURT: All right. Does the petitioner rest?

MS. FERRY: Yes. Yes, we do.

MS. ODEN: Your Honor, we're ready to call Dr. Allen. Could we have just a five-minute break?

THE COURT: Sure.

(Recess from 10:19 a.m. to 10:24 a.m.)

THE COURT: All right. Dr. Allen. I think you were previously sworn, correct?

THE WITNESS: I was, Your Honor. Thank you.

THE COURT: Very good. Thank you.

DIRECT EXAMINATION

BY MS. ODEN

Q. Good morning, Dr. Allen.
A. Good morning.
Q. I would like to start with talking about your qualifications and your educational background, if I may.
A. Yes, ma'am.
Q. What do you do for a living?
A. I'm a psychologist in private practice.
Q. Okay. And do you distinguish between clinical psychology and forensic psychology?
A. Yes, ma'am.
Q. Are you a clinical psychologist or a forensic psychologist?
A. My practice revolves around forensic psychology. I haven't done any counseling since about '02. I began winding that part of my practice down.
Q. Okay. Tell us about your educational background as it applies to your profession.
A. I have a bachelor's degree in psychology from Western New Mexico University. My master's degree is in psychology from Texas A & M University.
Q. From?
A. Texas A & M University. My Ph.D. is in psychology from Texas A & M at Commerce.
Q. And was that a Master of Arts degree?
A. No. It's an M.S. in experimental psych at A & M.
Q. And an M.S. stands for?

A. Master of Science.
Q. And what's the difference between a Master's of Arts in psychology and a Master's of Science in psychology?
A. Well, you can have departments in universities that -- a major university will have a College of Science, a College of Art, a College of Medicine or a law school, and some psychology programs are in the College of Arts. That tends to be things like educational psychology, school psychology maybe.

At A & M, when I was there, they didn't have a Ph.D. program in the science department. They had a Ph.D. program in the College of Education, which was in educational psychology.
Q. And, so, tell us a little bit more of the Master of Science degree in experimental psychology.
A. Well, it's general experimental psychology and when you have that kind of a program, it usually involves a little neuroanatomy and, you know, putting electrodes in rat brains and things like that.
Q. Okay. Do you have a doctoral degree in psychology?
A. Yes, ma'am.
Q. And where did you get that degree?
A. That was Texas A & M at Commerce.
Q. Okay. What was your minor when you were doing your --
A. Statistics.
Q. Let's talk about a little bit about your professional

experience. Where did you start out working when you were finished with your education?

A. After I got my master's degree, I went to work at Rusk State Hospital.

Q. And what is Rusk State Hospital?

A. It's, you know, a large state mental health facility, inpatient psychiatric facility. At the time it had two sections. One was for the civilly committed and one was for the -- what we call the criminally insane, the maximum security unit.

Q. And was that where you were working?

A. Ultimately. My first position, I hadn't quite completed my master's degree. I was still running data for my thesis or writing on my thesis, but I worked as a treatment coordinator, which was a day treatment program for the chronic psychiatric patients.

Q. And when you say a day treatment program, does that mean that it was not inpatient?

A. No, it was inpatient, but patients would be referred from other units in the hospital. We might have patients from the mental retardation unit, the chronic psychiatric unit. They would come to us during the day, where we would manage them during the day and try to teach them things.

Q. Okay. And was your role as a treatment coordinator a clinical role, a treating role?

A. Well, yes, in that I was responsible for designing and implementing the BMOD program. We had a system of, you know, reinforcements and they could earn points and trade them in when they had good performance, and so I supervised the staff, with people teaching them all kinds of things, from pictures, colors, math. And, so, I was responsible for supervising that staff and making sure that they were applying principles of behavior modification appropriately.

Q. Okay. And that's what "BMOD" stands for?

A. Yes, ma'am.

Q. Okay. You said that that was your first position at Rusk State Hospital. What was your next position at Rusk?

A. Actually that's when I did my predoctoral internship. I worked for about a year in the maximum security unit. And, you know, it's very much a rookie role. I was supervised by the director of psychology for the maximum security unit. And there were several other master's level people there, but I also had to report to the medical director, who was a psychiatrist.

Q. And when you say it was a maximum security unit, tell us what kind of offenses would have resulted in someone being assigned to the maximum security unit.

A. Well, parallel to what we do today up at Vernon State Hospital, you had people who were criminally committed. That means they had charges and they were sent there for maybe

pretrial evaluations, competency to stand trial, sanity determinations, things such as that. Some of them then were not there for very long. They might be under observation, and we do an evaluation within a week or two. But others were there under long-term commitments and we couldn't put them in the civil section because of their violence levels, for example.

Q. Okay.

A. And, so, I was, you know, a rookie. I was learning. But I was a part of the treatment team and we would do weekly staffings on patients, to make various decisions regarding competency, sanity, risk for violence, can we move them to the civil section, things like that.

Q. Okay. Were you working with any patients that had any psychotic disorders in the maximum security unit?

A. Yes, ma'am. We saw the entire spectrum of psychotic disturbances. We saw people who were mentally retarded. We saw people who were mentally retarded and mentally ill. We saw people who were mentally ill. And the criminal charges could vary. I mean, they're almost always felonies, but they could vary from, you know, burglary of a habitation to serial killing, mass murder, bank robberies, things like that.

Q. So, I see on your CV, which is Respondent's Exhibit 51, that you were the staff psychologist in the maximum security unit for a year. After you were a staff psychologist, did you

stay at Rusk State Hospital?
A. Yes, ma'am.
Q. And what did you do next at Rusk?
A. I think the next thing I did was, they actually kind of promoted me into -- not kind of. I got a promotion. They wanted me to run a unit for the chronic psychiatric patients and set up a behavior modification program there. We had -- of course, the population in the state hospital then was huge. It's been reduced now with budget cuts and everything. But there was a chronic psychiatric unit with -- I mean, it had two or 300 patients on it. So, a big staff of what we call psych techs, psychiatric nurses, various levels of therapists. We had a psychiatrist. And, so, my job was to set up and run a behavior modification program on that unit.
Q. Now, you said there were about two to 300 patients. Is that two to 300 at any given time or a total of two to 300 for the entire year?
A. Well, two to 300 in a given time, although at that point most of that two or 300, most of them had been there a long time and were going to be there probably until they passed. So, it was a pretty stable population, but, yeah, there was some turnover.
Q. Okay. I would assume that some of the people there had schizophrenia or other psychotic disorders?
A. Yeah, virtually all of them were chronic schizophrenics.

Q. What was your next position at Rusk?
A. Well, somewhere in there I worked on -- we had what we call a dual diagnosis unit for mentally retarded persons who were also mentally ill. And we had a master's level psychologist. He got pretty sick and so Dr. Thompson moved me over there to fill in his role for, I forget, six months or so. And, of course, I did the things you do with mentally retarded persons. We had admits and I did the IQ testing and we did usually the violent to excessive adaptive behaviors and I helped -- we didn't have a formal BMOD program there at that time, but I did help the nursing staff kind of apply those principles to manage some of the mentally retarded clients.
Q. So, the discussion that we've had so far, does that pretty well cover the length of time that you were employed at Rusk State Hospital?
A. No, actually I think one of the most important experiences, aside from the maximum security unit, was when I was a psychologist on the admissions and diagnostic unit.
Q. And tell us about that.
A. That is civilly committed patients would be brought from various counties depending on what your catchment area is pretty much on a weekly basis and they would go through a process of first going to the unit nurse where they would do initial screenings, take their weight, blood pressure, et cetera, and then they would get a screening evaluation by the

psychologist, which was me. Later they added another one, because it was just too big of a workload for one person. And we would do an initial screening and then take that to the psychiatrist, which would shorten his time that he had to spend with them. And then based on that, he would write initial orders for whatever was needed, medications or lockup or whatever.

So, I basically screened all the civilly committed patients at Rusk State Hospital for around three years. And, of course, I saw the entire spectrum of, you know, affective disorders, thought disorders, even some mentally retarded people were admitted that way.

Q. Okay. What does it take to be civilly committed?

A. At the time -- and I don't think that statute has changed or has changed much at this point, but basically it involves demonstrating a risk of harm to yourself or others.

Q. And is that different from what it takes to be criminally committed? I would imagine criminal commitment means you already hurt yourself or others?

A. Yeah, and you've got a charge pending and you're committed because the judge sends you there.

Q. So, in your three years in the diagnostic admissions portion of Rusk State Hospital, about how many patients do you think that you saw?

A. At Rusk?

Q. Yes. And not in your entire time at Rusk. I'm talking about that three-year period where you were doing the diagnostics upon their admission civilly.
A. In that three-year period? I mean, a thousand wouldn't surprise me in that time frame.
Q. Okay. And do you have any idea about over your time entirely at Rusk about how many patients you saw?
A. Maybe 5,000. I mean, we dealt with in maximum security alone about 800 per year.
Q. Okay.
A. And that was high turnover there. But there were a few that were there permanently because of the violence issue, but in a year you're going to see 800 just there alone.
Q. And is there any way that you can approximate of the number of patients that you saw about how many would have had psychotic disorders?
A. Well, when I was on -- they all did. I mean, when I was on the admissions unit, they were basically being admitted because they were psychotic --
Q. Okay.
A. -- and a danger to themselves and others, and then all the other ones, especially on the chronic psychiatric unit, even in day treatment, they were all psychotic. In maximum security, I mean, a lot of them were psychotic, but then in that setting, there was a much more prominent issue of malingering. That was

an issue, too, on the admissions and diagnostic issue, but the motive for malingering there was a little different.

Q. Well, we'll get to that in just a second. I want to retreat just a little bit and ask, you mentioned that you administered IQ tests and other tests. Would you say that you had few or many occasions to administer psychological assessments using formal testing measures?

A. Many.

Q. Okay. And what kind of tests did you administer in general?

A. There were individual intelligence tests, like the Wechsler or the Stanford-Binet. In maximum security you use group testing a lot, such as the Beta, the Beta IQ, because it's nonverbal. You give it to a bunch of people, and we used it as a screening device. Tons of personality testing, like the good old, you know, MMPI or similar kinds of things.

Q. Did you have any occasion to administer neuropsychological tests, like the Wisconsin Card Sorting Test or the naming tests?

A. I did some of that. When I was there, Dr. Thompson always made us go to continuing education. So, I got trained early on on using the Halstead-Reitan Battery, although since then I've never used the battery. But, yeah, you would do things like the Wisconsin Card Sort Test, the Boston Naming Test. Trail Making A and B is a nice way to assess some cognitive

functioning-type issues. Parts of the Halstead, like finger tapping, to assist different, you know, brain behavior relationships or functioning. Of course, IQ testing was always part of a neuropsych evaluation.

Q. Are you familiar with the tests that Dr. Roman administered to Mr. Eldridge in this case?

A. Yes, ma'am.

Q. Have you administered those tests yourself to other patients?

A. Yes, ma'am.

Q. So, I would like to talk a little bit about while you were at Rusk, your working with psychiatrists and your knowledge of psychological treatments involving medication. Did you have few or many occasions to work with a psychiatrist and observe their treatment regimen of medications?

A. Yes, ma'am.

Q. Few or many?

A. Many.

Q. And would you work in -- tell me about the relationship that you would have with a psychiatrist and their treatment protocols.

A. Well, it was always a team approach. The psychiatrist typically ran the team. On admissions and diagnostic, it was just a three-person team. It would be the psychiatrist, the unit nurse, and then myself.

Get them started on medications. The nurse would come back with feedback -- usually the nurse, about how they're doing on those medications. And then when I interacted with them, if I saw anything that I felt like I needed to report, then I would bring it up. You know, if he started them on 800 milligrams of Thorazine, are they showing extrapyramidal symptoms, are they getting too uncomfortable --

Q. What's extrapyramidal?

A. Just -- call it just a side effect of the antipsychotics. And with the older antipsychotics, they were truly common.

Q. So, specifically when you were at Rusk State Hospital, we're talking about a time period in the 1970s, correct?

A. Yes, ma'am. I was there '74 to '81.

Q. Okay. So, were you familiar with the medication Thorazine?

A. Yes, ma'am.

Q. Was that used on few or many of the patients that you treated?

A. Many.

Q. Was Risperdal or risperidone a medication that was used at Rusk?

A. No, it hadn't been developed yet. Thorazine, Navane, Stelazine, Mellaril were the big four of the old school antipsychotics.

Q. Okay. One of the medications that you mentioned was Navane?

A. Yes, ma'am.
Q. And that's the same Navane that we talked about in Mr. Eldridge's case?
A. Yes, ma'am.
Q. Did you have few or more occasions to observe the effect of Navane on patients that were under your care?
A. Yes, ma'am.
Q. One of the things that you mentioned was malingering in the patients that came to Rusk. What does malingering mean in that context?
A. Simply the false production of symptoms for some sort of gain.
Q. And when you mentioned a few minutes ago, you said that they had a different motive, tell us more about that.
A. Well, in a criminal setting, the typical motivation can be identified with an external goal, you know, avoiding criminal prosecution, things like that. In the civil section, what we dealt with a lot was other external motives, such as looking for, you know, three squares and a bed. And, you know, as the weather changed, we get more people seeking admission to the hospital to get out of the weather.
Q. Okay.
A. And, so, you know, the superintendent -- and we were beginning to really face budget issues then -- said, you know, as much as we want to help them, we've got budget limitations

and you guys have got to do a better job of screening those people that are just looking for three squares and a cot.

But also in the civil section you're more likely to see malingering for internal motivations, what we call some kind of somatoform disorder or factitious disorder, where they want to assume the sick role. It's a psychological goal, they like it.

Q. Okay. Would you say then that in the criminal portion -- the criminal commitment section of Rusk and in the civil commitment section of Rusk, that in both cases the malingering would be an attempt to display more symptoms or be sicker than they really were?

A. Correct. Let's assume that their actual sickness is zero. They could be making up symptoms going, we'll say zero to ten, or they could actually have some illness, but they're exaggerating it because of some motive, but both are malingering.

Q. Would you say you have a small amount or a large amount of experience in distinguishing between people that start out at zero, they're not at all ill and they're malingering versus people that do have illness and they're exaggerating or making up an entirely separate disorder?

A. Yes, ma'am, I've seen both quite a bit.

Q. So, were you -- did you administer -- what did you do when you were at Rusk to determine the presence of malingered

symptoms?

A. We did not have the methodologies that we have today. If you could give them an MMPI, for example, that could help you assess malingering, because it's got some scales on it that measure exaggeration. Other than that, it was all about clinical judgment and assessing the core issue of malingering, which is always about consistency issues in one form or another. You know, is what they're claiming consistent with what we know about mental illness; is it consistent with what we know about delusions; is it consistent with what we know about hallucinations; is it consistent with what we know about not just primary but the secondary symptoms or the negative symptoms of schizophrenia, for example; is what they're claiming consistent or inconsistent with their behavior; you know, if they have such and such a delusion, is their behavior consistent with that delusion.

So, it was much more clinical and we didn't have -- like on cognitive malingering, we didn't have the Word Memory Test. We didn't have the Test of Memory Malingering. We didn't have the SIRS back then or the M-FAST or the SIMS or those kinds of devices.

Q. When you were using clinical judgment to assess whether a person was malingering, was that an accurate way of assessing their effort?

A. Well, I mean, in a word yes, if you do it systematically,

if you go by what's laid out, you know, in the research literature that's been proven effective. It just -- being able to add objective measures, you know, can really be helpful in confirming. Because even now it's all about clinical judgment and assessing them clinically regarding the quality of the symptoms they're claiming and comparing that to external sources of information. And it's sort of like if you're claiming a back injury but competing every weekend in jujitsu, then your personal jury claim may not have some validity to it, that kind of thing.

Q. What about using clinical judgment to evaluate your subjective impression, for example, watching someone perform certain tests and saying that they appeared to do their best, they appeared to give good effort, is that an accurate method of assessing their effort?

A. It's really not. And I'm as guilty as a lot of psychologists. For years that's what we did. You give someone an IQ test and he appeared to be making good effort, so you put that in your report, that he appeared to be making good effort; therefore, I consider the results of the IQ test to be accurate, when, in fact, research later showed us that those kind of off-the-cuff clinical judgments were inaccurate.

And it was later demonstrated that with all neuropsych measures, half the variance is due to effort. People who make good effort have higher scores. People who

make poor effort have lower scores, regardless of their actual neuropsychological status. And, you know, when that's demonstrated to you with research, it's pretty shocking. But you, you know, all these years, say, well, yeah, he's making a good effort, so his IQ of 100 must be accurate. But it turns out, you know, it could very well be that his IQ should have been 115.

Q. I would like to go back to your professional experience. You said you were at Rusk until, I believe you said 1981?

A. Yes, ma'am.

Q. What kind of experience professionally did you have after that?

A. Well, after I got out of graduate school, I went to work at Mother Frances Hospital in Tyler. And I was director of the psychiatric unit there. It was a 30-bed inpatient psychiatric unit. There were -- I forget now, four or five psychiatrists in private practice who admitted patients there. And then we had a therapy staff of four or five or six people, somewhere in there, that I supervised.

Q. About how many patients do you remember seeing -- or how many patients do you think you saw while you were at Mother Frances?

A. Well, it was a 30-bed inpatient unit. The average length of stay was about three weeks. I can't do that math in my head.

Q. Did you usually have all the beds full?
A. Yes, ma'am.
Q. Okay. And what kind of disorders would cause someone to come to Mother Frances?
A. Psychotic states. It might be psychotic mood states and they were, you know, really suicidal or something like that, severely depressed, bipolar disorders, or manic phases. Schizophrenia was pretty commonly seen as well.
Q. And did you have to be considered --
A. Well, I should point out, we also saw a lot of substance abuse patients.
Q. Okay. Did you need to be concerned about malingering of the disorders at Mother Frances in the same way that you had to worry about it at Rusk?
A. No, ma'am. I don't remember us ever addressing the issue of malingering at Mother Frances.
Q. And was that simply because the patients were different and this group of patients weren't malingerers or was that more of an institutional culture?
A. One, it's rarely an issue when people are either voluntarily or civilly committed to a private facility.
Q. Why is that?
A. Why am I going to fake my symptoms if it's going cost me money, at least an insurance claim, and their copays and deductibles. So, that motive just typically isn't there in a

private facility. I do remember a case, but it was at University Park Hospital. They built the hospital and moved the unit there and the 30-bed unit became a 90-bed inpatient psych hospital.

Q. Was that the next place that you worked after Mother Frances?

A. Yes, ma'am. I became a -- of course, the staff expanded, but I became what was called the clinical director there. And we had an adult unit, a substance abuse unit and later a pediatric unit.

Q. And were you working in the adult unit at University Park Hospital?

A. Yes, ma'am.

Q. And --

A. Well, I mean, I designed the programs for all three of them.

Q. Okay. And were they the same type of patient as you saw at Mother Frances?

A. Yes, ma'am.

Q. And would you say that they have the same disincentive for malingering?

A. Yes, ma'am. I mean, I can remember one case, a young man who was admitted, and I later found out, like within 48 hours, that he was in criminal trouble, that a murder had been committed, and there was later questions about the veracity of

his presentation.
Q. Okay. And did you develop your doubts about his presentation because of his presentation or because somebody else told you that he was probably malingering?
A. Nobody told me he was probably malingering, but I was at the front door when the police showed up. The psychiatrist insisted that he wasn't malingering. I didn't assess him. So, I don't know.
Q. Okay. All right. So, how long were you the director of clinical services either at Mother of Frances or at University Park Hospital?
A. That whole total time I think was maybe two years.
Q. Okay. You mentioned that you were the director. Were you creating any directives for the staff to watch out for things like malingering?
A. No, we never did any formal discussions of malingering for the staff.
Q. Okay. To your knowledge, if you have personal knowledge, is that common among other private mental health institutions, like hospitals?
A. Yes, ma'am. It's just rarely considered as an issue. To demonstrate it, there's a rather classic study called the Rosenhan study that received a lot of attention. And in the Rosenhan study what happened is they took normal people, I think 8, 10, 12 of them and had them go to -- I forget how

many, 6, 8, 10, 12 mental hospitals and present with either no or very minimal odd hallucinations. For example, why are you here today? Well, I keep hearing this clicking sound in my mind.

They were all admitted. They all got diagnosed, most of them with psychotic diagnoses, even though after admission they never said another thing about symptoms. There was no effort to rule out malingering.

And it doesn't mean that all the psychiatrists and psychologists and psychiatric nurses are stupid idiots. It simply means it's not an issue in that kind of a setting. It just rarely comes up as an issue.

Q. And when you say an odd hallucination, do you mean that's really crazy or do you mean it's atypical?

A. Atypical. Not typical.

Q. Okay. Going back to your personal experience, after you left University Park Hospital, what did you do professionally?

A. I went into private practice. Initially I started working with a psychiatrist, but basically we developed an inpatient chronic benign pain program at East Texas Medical Center and began seeing patients with chronic benign pain, spine pain, generally. And I began working with a lot of physicians. I worked with a lot of the neurosurgeons and orthopedic surgeons who did elective spine surgery, to help sort out patients who might be engaged in malingering for external goals, like

winning a lawsuit or malingering because they like the sick role and would subject themselves to multiple surgeries. But I also consulted for, you know, internists, oncologists. General practitioners might have a patient admitted to the hospital who was depressed or something.

Q. During this time that you were in private practice, how many years was that, or from when to when?

A. Well, I started private practice, like, in around '85 to '86, somewhere in there, until now. The chronic pain stuff, I got involved with -- or what we call behavioral medicine, I was engaged in that for about ten years through the chronic benign spine pain program and then I was director of the preoperative evaluation program and that's where I helped the spine surgeons rule out patients they didn't really want to cut on, because they were extremely reluctant to use the word "malingering" in a medical setting, because you're actually more likely to get sued for not giving treatment than if you give treatment. But if you give treatment and they're not going to respond because of malingering issues, you've got to have a hat to hang your hat on. And, so, I was sort of their scapegoat, you know, because they could say, well, the shrink said, you know, that this was a factitious disorder.

Q. Okay. During the time that you've been in private practice, did you ever have occasion to treat someone with a psychotic disorder?

A. In my counseling practice I didn't see people who were actively psychotic. There were occasions I saw some who were on medication and they had the history, but they weren't actively hallucinating. It was well controlled with medications.

Q. Okay.

A. The only time I really was involved in treatment directly was on an inpatient basis.

Q. Okay. And speaking specifically about your private practice, your counseling practice, the patients that you saw with controlled psychotic disorders, about how many would you say you saw?

A. Not that many. I'm not sure I could count them. I mean, it was an issue that came up. Now, this is the counseling practice. I mean, when I do -- when they're in jail, I mean, I run into psychotic disorders. That's a different deal.

Q. Yeah, I'm leaving that aside.

A. Right.

Q. I'm just talking about your clinical, therapeutic experience with people with controlled psychotic disorders.

A. It wasn't that frequent in my counseling practice.

Q. Okay. Would you say less than 50?

A. Yeah, it would be less than 50 probably in those years.

Q. Okay. And then at some point did you kind of cease being in this behavioral medicine role dealing with the people with

benign pain or are you still doing that practice now?
A. No, I'm not doing that. I mean, I started getting out of that, well, for personal reasons, in '96. I changed my whole practice. In '97 my wife got sick, and so I totally changed my practice.
Q. And what direction did your professional practice take at that point?
A. Well, I actually started to get more involved in forensic psychology in '87.
Q. Okay.
A. Because of my background -- with my predoctoral internship, my strength was actually forensic psychology, you know, and then in '87 I started to get a smattering of requests to do competency to stand trial examinations, but because I saw so many medical patients, too, I started getting involved in civil litigation, you know, medical malpractice, personal injury claims, and I did some of that, but I haven't done any civil stuff now. I turn those cases away now.
Q. Okay. So, in the civil forensic work that you did, did you have few or many occasions to be asked to address issues of malingering?
A. It was a common issue in any kind of -- yeah, there's often external goals, financial gain.
Q. And when would you say you started really developing your criminal forensic psychology practice?

A. Well, in terms of practice, that actually began around '87, '89, in that time frame. I was just so busy with other things I couldn't -- I couldn't take just those kind of criminal cases. But my work in criminal cases just gradually escalated in the, you know, early and mid-Nineties and I began doing capital cases and competency to stand trial and sanity and risk assessments and things like that. And then it just became almost totally criminal work by 2002.

Q. And in your criminal forensic practice, about what proportion or if you would rather say it in terms of numbers, about how many inmates or offenders, whatever, would you say had a psychotic disorder? Let me back up. Let me ask, how many presented as having a psychotic disorder?

A. Well, it's not -- I'm not sure if I could give you a number. It's not at all uncommon, and actually I think the frequency is increasing as, you know, state hospital budgets are shrinking and more people are on the streets and a lot of them are chronically psychotic and they're showing up in our jails. Some weeks if I do, say, three, four, or five exams, none of them may be psychotic. I think last week I did four, and three of them were actively psychotic.

Q. And what kind of exam are you talking about?

A. Competency to stand trial -- well, some of them are sanity.

Q. Okay. And of the patients who are presenting as having a psychotic disorder, how many would you say you have determined

to be malingering?
A. I don't know that I can give you a number. The incidence of malingering in these criminal cases, when you're dealing with someone who's in jail is pretty high. I run into it often. I have to screen for it routinely. You have to. And there are studies on it, you know, whether it's cognitive malingering or psychiatric malingering, as to the, you know, the incidence, the frequency of it, because there's a lot of variability in the studies. I mean, some have reported an incidence rate as high of 70 percent of malingering, others as low as 8 percent malingering and everywhere in between.
Q. And as you've worked on these criminal forensic cases, have you had the opportunity to observe people with psychotic disorders that are being treated with psychotropic medications?
A. Yes, ma'am.
Q. And would you say that you're familiar with how people react to medication and how it changes their symptoms?
A. Yes, ma'am.
Q. Okay. I see on your CV that you have taught psychology at universities. Have you ever, as part of your teaching, taught about psychotic disorders?
A. Well, sure. I mean, I've taught introductory psych, social psych, applied psych, history of psych. And certainly you're going to touch on that in introductory psych and more so in applied psychology.

Q. You've never taught a class specifically about psychotic disorders?

A. I've never taught --

THE COURT: You mean wholly devoted to?

MS. ODEN: Yes, ma'am.

A. I've never taught abnormal psychology, and I don't even know of a course that would be devoted totally to psychotic disorders.

Q. Okay. Have you also taught your students about the detection of malingering?

A. No, I never taught that in school.

Q. Do you currently participate in any professional organizations that focus on forensic psychology or the issues that we've talked about in this case?

A. Well, I mean, I'm a member of the American Psychological Association and then I'm a member of the chapter on law and psychology.

Q. And does that have a regular participation or focus on issues like malingering of --

A. Oh, yeah, it comes up. It gives you access to their journal. You get their journal. You join, so you get the quarterly journal on *Law and Human Behavior*. And, of course, malingering shows up as a topic and then competency shows up, all of those kinds of issues.

Q. And do you regularly read the literature from your

profession that deal with the issues that came up in Mr. Eldridge's case?

A. You're going to have to restate that one.

Q. Do you regularly read the literature from your profession that deals with issues that like malingering or psychotic disorders?

A. Well, I mean, yeah, I do my best to keep up, you know, with what I think is relevant.

Q. Okay. And tell me about any continuing education that you've participated in that you feel is particularly important for the Court to consider.

A. Well, I mean, the Board requires us to go to continuing education every year. I think now we're required to get 12 direct hours a year. So, I've been to a lot of different ones. Most of them, the ones I prefer going to are put on by the American Board of Forensic Psychologists. And they do a really good job of focusing in on and providing ongoing training related to topics relevant to forensic psychology, whether it's assessing child sex abuse allegations or competency, insanity, various psychological tests that are used in the field.

Q. I'm looking at page 2 of your CV under continuing education, and I'm wondering if I mistakenly gave an old version of your CV as an exhibit, but I see that there is not a class listed for 2012 or 2011.

A. Well, I've got continuing education for 2011. This would

be an older one.
Q. Okay.
A. I haven't gone yet in 2012. If you can give me a moment. I just don't remember. In 20 -- last year, in 2011, I got 14 hours of continuing education. It was with the American Board of Forensic Psychology. Let's see, seven of the hours were ethical issues in forensic practice. There was another seven, and I'm not sure what it was in.
Q. If you don't remember right now, that's fine. I'm sure that we'll have another chance another day to talk about it. Do you see any other recent continuing education that you participated in that was especially important for the Court to consider?
A. Yeah, I went to Richard Rogers' seminar in February of 2010 in New Orleans. It was his seminar on the SIRS-2.
Q. Okay. And how long was that seminar?
A. I got seven hours of credit for that.
Q. Okay. And was the whole thing just about the SIRS-2?
A. Primarily about the SIRS-2. He got into topics about malingering in general, but then it was all about the development of the SIRS-2, how it compares to the SIRS-1, you know, it's different, things like that.
Q. Prior to that seminar, had you administered the SIRS-1 to other patients -- to patients in general, I should say?
A. Yeah, I'd used it in some criminal cases, of course, yeah.

Q. And did you already have the SIRS-2 when you went to this seminar in 2010?
A. No.
Q. And after the seminar, did you decide to buy the SIRS-2?
A. Well, actually going to the seminar, I got a bunch of free pamphlets, which was pretty nice of him to hand out, and then I just bought the manual that goes to the SIRS.
Q. Okay. Did you buy the actual test itself?
A. No, I got freebies from him. I think he gave us about half a dozen.
Q. Okay. Have you ever administered the SIRS-2?
A. No, ma'am.
Q. Do you find it a persuasive or compelling test for assessing malingering?
A. No, ma'am. I'm having some real problems applying the -- using the SIRS-2, actually especially after attending his seminar.
Q. Okay. We'll talk about that more in detail when we talk about the actual SIRS-2 in this case. Were there any other recent continuing education sessions that you think are particularly important?
A. Well, I did ethics again last -- or in 2010. You know, they're all relevant to what I do, including this case. I go to some kind of ethical thing every year. It's required by the Board, if nothing else. But, you know, assessment of

malingering, assessment of psychopathology are all seminar-type things that I've attended.

Q. About how many times would you say you've done an assessment of someone's competency to stand trial?

A. Oh, man, a bunch. Hundreds, thousands.

Q. Okay. When you say thousands, do you mean maybe just one or two thousand? Let's try to narrow it down just a little bit.

A. At least a thousand, I'll say, surely.

Q. Okay. And how many times have you evaluated someone for competency to be executed?

A. I was only involved prior to this in one case, and that was *Panetti*.

Q. Okay. Would you say that your experience in evaluating someone's competence to stand trial is applicable to your experience in a competency for execution assessment?

A. First thing, the legal background is different. There's a specific statute in Texas outlining the criteria they want you to follow for a competency to stand trial. In that sense, the competency to stand trial statute is pretty specific.

On the competency to be executed, you know, from my point of view and discussing this with my colleagues, it's actually a pretty low threshold, I'll call it, and is simply rational understanding. It's essentially based on the *Ford v. Wainwright* -- did I say that right? -- ruling and *Panetti*, a

rational understanding, and that's about it.

Q. Do you do the same kind of things to assess someone's competence to stand trial that you would do to assess their competence for execution?

A. Not exactly, in that competency to stand trial, in my opinion, and most of my colleagues, the way they do it, the way I've been trained to do it, is you use a real structured format and you ask really specific questions that help determine if someone is competent to stand trial. You know, have you got a lawyer? What's your lawyer's name? Those kinds of things are real specific. You will ask questions that are very specific to competency that cover the areas about factual and rational understanding, capacity to cooperate and collaborate with their attorney rationally and so on.

With competency to be executed, no such format exists. There's no tests. There are tests for competency to stand trial. There are no tests for competency to be executed, or none that I know of. So, it's in a sense much more clinical. Both have the same issue of external motives related to malingering issues. Both have the same potentials for having to reconcile symptoms, psychotic symptoms, thought disorder versus mood disorder, how does that impact competency. Both issues can involve, well, the person is schizophrenic, but they're still competent to stand trial. The person is mentally retarded, but they're still competent to stand trial. You have

the same issue with competency to be executed.

Q. Do you have to do similar kinds of record reviews in both cases?

A. No, ma'am. Competency to stand trial is a very routine issue for -- usually a district court issue. Competency to be executed is much more rare. You just -- you know, you can't make a living if that's what you're going to do, only competency to be executed.

THE COURT: When you get to a convenient stopping point, we will stop.

MS. ODEN: I think this is probably a good time. I was just about to get into the next section.

THE COURT: Okay. I thought that might be true.

All right. So, we have a date to resume. The Rule has been invoked, but not as to experts. So, I think that will make that easier.

Anything else we need to take up between now and then?

MS. FERRY: Your Honor, it just occurred to me that neither petitioner nor respondent offered any of our exhibits under seal, including the raw data. But I imagine that Ms. Oden and I can speak and submit something in writing about which exhibits.

MS. ODEN: I thought we already had an order in place about the raw data and the notes being -- that they would be

admitted under seal.

THE COURT: Okay. What I need you to do is get me a list of the exhibits that need to be treated in that fashion and a list that can be admitted without having to worry about the sealing.

MS. ODEN: No problem.

MS. FERRY: We'll do that, Your Honor.

MS. ODEN: We'll do that.

THE COURT: All right. Good. Thank you very much. You may step down, sir.

THE WITNESS: Thank you.

THE COURT: I know that there's a statement, but probably if it's going to take more than five minutes, you'll need to submit it in writing.

MR. WIERCIOCH: It shouldn't take more than five minutes, Your Honor.

THE COURT: Okay. Do it as quickly as you can, please. Thank you.

MS. ODEN: So, can you just let us know when we can come back in?

THE COURT: Yes. Not yet. Thank you.

(The respondent's attorneys and parties left the courtroom.)

(Ex parte part sealed, not transcribed.)

(Concluded at 11:30 a.m.)

* * *

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled cause, to the best of my ability.

/s/ Kathy L. Metzger 5-25-12

Kathy L. Metzger Date

Official Court Reporter